FOR OHF USE

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040956

Facility Name: THE WEALSHIRE

Address: 150 JAMESTOWN LANE (Number) LINCOLNSHIRE (City) 60069 (Zip Code)

County: LAKE

Telephone Number: (847) 883-9000 Fax # (847) 883-9029

IDPA ID Number: 363952069001

Date of Initial License for Current Owners: 08/15/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ZENY ENGRACIA Telephone Number: (847) 883-9000

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) ARNOLD GOLDBERG

(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,940	1
2		Skilled Pediatric (SNF/PED)			2
3	42	Intermediate (ICF)	42	15,372	3
4		Intermediate/DD			4
5	12	Sheltered Care (SC)	12	4,392	5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,704	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,528	26,640	4,838	33,006	8
9	SNF/PED					9
10	ICF	2,316			2,316	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,844	26,640	4,838	35,322	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.02%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Daycare

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/14/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/14/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 44 and days of care provided _____

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	206,223	19,141		225,364		225,364		225,364			1
2	Food Purchase		233,375		233,375	(9,700)	223,675		223,675			2
3	Housekeeping	297,508	24,975		322,483		322,483		322,483			3
4	Laundry	61,408	28,423		89,831		89,831		89,831			4
5	Heat and Other Utilities			208,241	208,241		208,241		208,241			5
6	Maintenance	89,956	17,315	142,792	250,063		250,063	925	250,988			6
7	Other (specify):*											7
8	**TOTAL General Services**	655,095	323,229	351,033	1,329,357	(9,700)	1,319,657	925	1,320,582			8
	B. Health Care and Programs											
9	Medical Director			13,775	13,775		13,775		13,775			9
10	Nursing and Medical Records	2,802,491	153,767	31,094	2,987,352	29,860	3,017,212		3,017,212			10
10a	Therapy	97,785	4,466	154,072	256,323	(28,521)	227,802		227,802			10a
11	Activities	348,646	11,532	9,398	369,576		369,576		369,576			11
12	Social Services	35,935			35,935	318	36,253		36,253			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,284,857	169,765	208,339	3,662,961	1,657	3,664,618		3,664,618			16
	C. General Administration											
17	Administrative	55,777		365,090	420,867		420,867		420,867			17
18	Directors Fees											18
19	Professional Services			94,721	94,721	(5,017)	89,704	(8,902)	80,802			19
20	Dues, Fees, Subscriptions & Promotions			78,849	78,849	3,500	82,349	(67,956)	14,393			20
21	Clerical & General Office Expenses	256,029	25,268	111,334	392,631		392,631	(92,691)	299,940			21
22	Employee Benefits & Payroll Taxes			625,495	625,495	9,700	635,195		635,195			22
23	Inservice Training & Education			2,290	2,290	(985)	1,305		1,305			23
24	Travel and Seminar			12,878	12,878	845	13,723	(2,794)	10,929			24
25	Other Admin. Staff Transportation			9,877	9,877	(2,031)	7,846	(1,530)	6,316			25
26	Insurance-Prop.Liab.Malpractice			1,186	1,186		1,186	181,345	182,531			26
27	Other (specify):*											27
28	**TOTAL General Administration**	311,806	25,268	1,301,720	1,638,794	6,012	1,644,806	7,473	1,652,279			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,251,758	518,262	1,861,092	6,631,112	(2,031)	6,629,081	8,398	6,637,479			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number THE WEALSHIRE #0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			39,564	39,564		39,564	770,799	810,363			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,537	11,537		11,537	1,278,954	1,290,491			32
33	Real Estate Taxes							127,258	127,258			33
34	Rent-Facility & Grounds			2,084,342	2,084,342		2,084,342	(2,084,342)				34
35	Rent-Equipment & Vehicles					2,031	2,031		2,031			35
36	Other (specify):* LOSS ON ASSET SALE							26,188	26,188			36
37	TOTAL Ownership			2,135,443	2,135,443	2,031	2,137,474	118,857	2,256,331			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			357	357		357		357			38
39	Ancillary Service Centers		84,697	(1,090)	83,607		83,607		83,607			39
40	Barber and Beauty Shops			43,187	43,187		43,187		43,187			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,072	76,072		76,072	(3,604)	72,468			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		84,697	118,526	203,223		203,223	(3,604)	199,619			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,251,758	602,959	4,115,061	8,969,778		8,969,778	123,651	9,093,429			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	292,568	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,604)	42		18
19	Entertainment				19
20	Contributions	(597)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,110)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,542)	21		24
25	Fund Raising, Advertising and Promotional	(37,342)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,273)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 189,100		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 189,100		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

THE WEALSHIRE

ID# 0040956

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SUPPLIES & INCENTIVES	$ (10,073)	20	1
2	MARKETING SALARIES	(54,375)	21	2
3	CREDIT CARD FEES	(16,810)	20	3
4				4
5	CHAMBERS OF COMMERCE DUES	(458)	20	5
6	MARKETING TERAVEL	(2,794)	24	6
7	MARKETING AUTO EXPENSE	(1,530)	25	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(86,039)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	925	0	0	0	0	0	0	0	0	0	925	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	925	0	0	0	0	0	0	0	0	0	925	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,110)	208	0	0	0	0	0	0	0	0	0	(8,902)	19
20	Fees, Subscriptions & Promotions	(67,956)	0	0	0	0	0	0	0	0	0	0	(67,956)	20
21	Clerical & General Office Expenses	(104,514)	11,823	0	0	0	0	0	0	0	0	0	(92,691)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,794)	0	0	0	0	0	0	0	0	0	0	(2,794)	24
25	Other Admin. Staff Transportation	(1,530)	0	0	0	0	0	0	0	0	0	0	(1,530)	25
26	Insurance-Prop.Liab.Malpractice	0	181,345	0	0	0	0	0	0	0	0	0	181,345	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(185,903)	193,376	0	0	0	0	0	0	0	0	0	7,473	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(185,903)	194,301	0	0	0	0	0	0	0	0	0	8,398	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE WEALSHIRE # 0040956 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	292,568	478,231	0	0	0	0	0	0	0	0	0	770,799	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	1,278,954	0	0	0	0	0	0	0	0	0	1,278,954	32
33	Real Estate Taxes	0	127,258	0	0	0	0	0	0	0	0	0	127,258	33
34	Rent-Facility & Grounds	0	(2,084,342)	0	0	0	0	0	0	0	0	0	(2,084,342)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	26,188	0	0	0	0	0	0	0	0	0	26,188	36
37	**TOTAL Ownership**	292,568	(173,711)	0	0	0	0	0	0	0	0	0	118,857	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	(3,604)	0	0	0	0	0	0	0	0	0	0	(3,604)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(3,604)	0	0	0	0	0	0	0	0	0	0	(3,604)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	103,061	20,590	0	0	0	0	0	0	0	0	0	123,651	45

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ARNOLD GOLDBERG	99	THE PONDS OF WEALSHIRE	LINCOLNSHIRE	LINCOLNSHIRE PR	LINCOLNSHIRE	BLDG PRTNRSH
THEWEALSHIRE, INC.	01	THE OAKS OF BURR RIDGE	BURR RIDGE	ALEXANDER BLAKI	SKOKIE	MGMT CO

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT INCOME	$ 2,084,342	LINCOLNSHIRE PROPERTIES, LP		$	$ (2,084,342)	1
2	V	19	ACCOUNTING FEES		LINCOLNSHIRE PROPERTIES, LP		208	208	2
3	V	26	INSURANCE		LINCOLNSHIRE PROPERTIES, LP		181,345	181,345	3
4	V	32	MORTGAGE INTEREST		LINCOLNSHIRE PROPERTIES, LP		1,278,954	1,278,954	4
5	V	21	OFFICE EXPENSES		LINCOLNSHIRE PROPERTIES, LP		11,823	11,823	5
6	V	6	MAINTENANCE		LINCOLNSHIRE PROPERTIES, LP		925	925	6
7	V	33	REAL ESTATE TAXES		LINCOLNSHIRE PROPERTIES, LP		127,258	127,258	7
8	V	30	BOOK DEPRECIATION		LINCOLNSHIRE PROPERTIES, LP		478,231	478,231	8
9	V	36	LOSS ON SALE OF ASSETS		LINCOLNSHIRE PROPERTIES, LP		26,188	26,188	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,084,342			$ 2,104,932	$ * 20,590	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ARNOLD GOLDBERG	OWNER	ADMINISTRATIV	99.00	NONE	35	70.00	ALLOC MGM	$ 365,090	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 365,090		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY LINCOLNSHIRE PROPERTIES, LP						$	$			$	1
2	DIAWA FINANCE CORP		X	MORTGAGE	$129,285.00	10/31/97	16,000,000	14,290,698	10/31/07	8.1500	1,219,555	2
3			X	MORTGAGE LOAN FEES AMORTIZED OVER 10 YEARS			593,987	168,294			59,399	3
4												4
5												5
	Working Capital											
6	1ST EQUITY LINE OF CREDIT		X	LINE OF CREDIT	DEMAND		250,000	248,968		5.7500	11,537	6
7												7
8												8
9	TOTAL Facility Related				$129,285.00		$ 16,843,987	$ 14,707,960			$ 1,290,491	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 16,843,987	$ 14,707,960			$ 1,290,491	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	122,305	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	121,563	2
3. Under or (over) accrual (line 2 minus line 1).	$	(742)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	128,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	127,258	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	107,637	8
2000	113,126	9
2001	114,629	10
2002	117,858	11
2003	121,564	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE WEALSHIRE COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0040956

CONTACT PERSON REGARDING THIS REPORT Zeny Engracia

TELEPHONE (847) 883-9000 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-15-200-062	Nursing Home	$ 121,563.57	$ 121,563.57
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 121,563.57	$ 121,563.57

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,477 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	273,375	1994	$ 970,925	1
2					2
3	TOTALS	273,375		$ 970,925	3

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	LINCOLNSHIRE PROPERTIES:			1995	$ 11,521,031	$ 317,142	20	$ 576,052	$ 258,910	$ 5,400,487	4
5	144										5
6											6
7											7
8											8
	Improvement Type**										
9	LINCOLNSHIRE PROPERTIES:										9
10	MUSIC SYSTEM			1999	33,003	846	20	1,650	804	8,594	10
11	SIDEWALK			1999	4,660	290	20	233	(57)	1,204	11
12	PATIO			2001	5,200	416	20	260	(156)	813	12
13	SIDEWALK			2001	2,325	186	20	116	(70)	363	13
14	CARPETING			2002	12,473	2,844	20	624	(2,220)	1,326	14
15	SPRINKLER SYSTEM			2002	6,805	589	20	340	(249)	779	15
16	REMODELING			2003	20,650	4,007	20	1,033	(2,975)	1,334	16
17	SIGNAGE			2004	6,000	857	7	286	(571)	286	17
18	REMODELING - WINDOWS PB			2004	9,411	471	15	627	156	627	18
19	REMODELING KITCHEN - CC			2004	34,889	4,986	7	2,492	(2,494)	2,492	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LEASEHOLD IMPROVEMENTS	1995	$ 34,126	$ 875	20	$ 1,706	$ 831	$ 15,682	37
38	LEASEHOLD IMPROVEMENTS	1996	4,059	339	20	203	(136)	1,719	38
39	LEASEHOLD IMPROVEMENTS	1998	3,993	0	20	399	399	2,527	39
40	ALARM SYSTEM	1999	9,183	235	20	459	224	2,422	40
41	SECURITY SYSTEM	1999	4,427	114	20	221	107	1,148	41
42	CABLING/WINDOWS/CABINETS/LUMBER/FIRE SAFETY/ETC	2000	23,775	610	20	1,189	579	5,450	42
43	SIGN	2000	1,611	41	20	81	40	358	43
44	BOILER WORK	2000	871		20	44	44	176	44
45	BEARING & ASSEMBLING	2001	1,136		20	57	57	209	45
46	PUMP W/MOTOR	2001	704		20	35	35	114	46
47	COMPRESSOR	2001	1,797		20	90	90	323	47
48	BOILER WORK	2001	1,722		20	86	86	337	48
49	BOILER WORK	2001	1,008		20	50	50	196	49
50	ROOF REPAIR	2001	500	13	20	25	12	85	50
51	PHONE SYSTEM	2001	1,713	44	20	86	42	337	51
52	BLACKTOP & PATCH	2001	4,799		20	240	240	960	52
53	CARPETING	2002	1,158	165	20	58	(107)	171	53
54	EXTERIOR DOORS	2002	9,700	485	20	485		1,021	54
55	BOILER REPAIRS	2002	8,124		20	406	406	1,218	55
56	SPRINKLER SYSTEM	2002	950		20	48	48	144	56
57	BLACKTOP REPAIR	2002	2,799		20	140	140	420	57
58	BOILER REPAIRS	2002	1,077		20	54	54	162	58
59	PUMP & BOILER REPAIRS	2002	3,376		20	169	169	507	59
60	FIRE SAFETY UPGRADES	2003	9,901		20	495	495	743	60
61	SEWAGE EJECTORS/DISPOSER/PUMP	2003	12,848	329	20	642	313	963	61
62	BORIS BARBARIC-PAINTING	2003	5,950	2,023	5	1,190	(833)	1,785	62
63	TELEPHONE LINES	2003	4,229	108	20	211	103	317	63
64	IRRIGATION SYSTEM BOOSTER PUMP/HEADS	2004	5,530	30	39	24	(6)	24	64
65	UPGRADE BOILER CONTROLS	2004	2,109	7	39	5	(2)	5	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,819,622	$ 338,052		$ 592,611	$ 254,559	$ 5,457,828	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,748,752	$ 27,089	$ 176,186	$ 149,097	3-20 YR	$ 1,661,088	71
72	Current Year Purchases	57,901	5,282	2,553	(2,729)	5,7,39 YR	2,553	72
73	Fully Depreciated Assets	88,001					88,001	73
74	LINCOLNSHIRE PROPERTIES	284,392	34,249	36,113	1,864	3-20 YR	147,445	74
75	TOTALS	$ 2,179,046	$ 66,620	$ 214,852	$ 148,232		$ 1,899,087	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		96 DODGE RAM	2001	$ 14,500	$ 1,775	$ 2,900	$ 1,125	5	$ 9,667	76
77										77
78										78
79										79
80	TOTALS			$ 14,500	$ 1,775	$ 2,900	$ 1,125		$ 9,667	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,984,093	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 406,447	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 810,363	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 403,916	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,366,582	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LINCONSHIRE PROPERTIES	$	$	$	86
87	COMPLETION OF BLDG 1996	58,161	1,491		87
88	LANDSCAPING	43,000	2,541		88
89	BUILDING 1997 SECT 754	4,482,861	107,316		89
90	DR OFFICE DEPRECIATION				90
91	TOTALS	$ 4,584,022	$ 111,348	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2002 MERCURY SABLE	$ 406.00	$ 2,031	17
18					18
19					19
20					20
21	TOTAL		$ 406.00	$ 2,031	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES
☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM ☐
IN OTHER FACILITY ☐
COMMUNITY COLLEGE ☐
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM ☐
IN OTHER FACILITY ☐
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	260 hrs	$ 10,399	4,564	$ 55,837	$ 4,466	4,824	$ 70,702	1
2	Licensed Speech and Language Development Therapist	10a-8	79 hrs	3,925	842	12,225	985	921	17,135	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	907 hrs	29,391	6,311	85,025		7,218	114,416	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				81,671		81,671	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): OXYGEN, LABS,	39-8				(1,090)	3,026		1,936	13
14	TOTAL			$ 43,715	11,717	$ 151,997	$ 90,148	12,963	$ 285,860	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (100,652)	$ (106,076)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance ---)	232,017	232,017	3
4	Supply Inventory (priced at cost)	35,656	35,656	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,196,963	1,725,552	8
9	Other(specify): Mortgage Escrows		130,880	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,363,984	$ 2,018,029	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,190,356	13
14	Buildings, at Historical Cost		17,001,379	14
15	Leasehold Improvements, at Historical Cost	114,996	298,088	15
16	Equipment, at Historical Cost	495,050	779,564	16
17	Accumulated Depreciation (book methods)	(396,131)	(7,582,811)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Replacement Reserves		284,788	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 213,915	$ 13,971,364	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,577,899	$ 15,989,393	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,434,681	$ 1,508,021	26
27	Officer's Accounts Payable	1,805,000	1,805,000	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	248,968	248,968	29
30	Accrued Salaries Payable	185,046	185,046	30
31	Accrued Taxes Payable (excluding real estate taxes)	215,926	215,926	31
32	Accrued Real Estate Taxes(Sch.IX-B)		128,000	32
33	Accrued Interest Payable		102,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,889,621	$ 4,192,961	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,290,698	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 14,290,698	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,889,621	$ 18,483,659	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,311,721)	$ (2,494,266)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,577,900	$ 15,989,393	48

*(See instructions.)

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,822,735)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(337,328)	3
4	RECLASS FROM OFFICER AP TO EQUITY	2,959,290	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,200,773)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,110,948)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,110,948)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,311,721)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,336,231	1
2	Discounts and Allowances for all Levels	(218,047)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,118,184	3
	B. Ancillary Revenue		
4	Day Care	270	4
5	Other Care for Outpatients		5
6	Therapy	684,693	6
7	Oxygen	7,994	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 692,957	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	42,147	13
14	Non-Patient Meals	35	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,317	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 47,499	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(50)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (50)	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Other Income-Employee Loan Fees**	240	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 240	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,858,830	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,329,357	31
32	Health Care	3,662,961	32
33	General Administration	1,638,794	33
	B. Capital Expense		
34	Ownership	2,135,443	34
	C. Ancillary Expense		
35	Special Cost Centers	127,151	35
36	Provider Participation Fee	76,072	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,969,778	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,110,948)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,110,948)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? T COMPLET If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,022	2,207	$ 69,568	$ 31.52	1
2	Assistant Director of Nursing	1,337	1,434	44,103	30.76	2
3	Registered Nurses	29,578	32,203	822,522	25.54	3
4	Licensed Practical Nurses	14,544	15,717	355,714	22.63	4
5	Nurse Aides & Orderlies	120,181	130,407	1,412,195	10.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	831	872	30,600	35.09	7
8	Rehab/Therapy Aides	1,885	2,061	38,663	18.76	8
9	Activity Director	1,614	1,846	43,118	23.36	9
10	Activity Assistants	23,152	25,285	305,528	12.08	10
11	Social Service Workers	1,501	1,673	35,935	21.48	11
12	Dietician	1,022	1,022	20,465	20.02	12
13	Food Service Supervisor	1,261	1,451	37,574	25.90	13
14	Head Cook	1,538	1,729	27,497	15.90	14
15	Cook Helpers/Assistants	2,118	2,229	29,254	13.12	15
16	Dishwashers	10,883	11,708	91,433	7.81	16
17	Maintenance Workers	4,642	5,019	89,956	17.92	17
18	Housekeepers	29,865	33,223	297,508	8.95	18
19	Laundry	6,043	6,965	61,408	8.82	19
20	Administrator	1,459	1,676	55,777	33.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,658	9,968	201,653	20.23	24
25	Vocational Instruction					25
26	Academic Instruction	1,087	1,230	28,521	23.19	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca NURSING SUPER	3,302	3,713	98,391	26.50	32
33	Other(specify) MARKETING	1,583	1,733	54,375	31.38	33
34	TOTAL (lines 1 - 33)	270,106	295,371	$ 4,251,758 *	$ 14.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		13,775	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		4,071	10-3	38
39	Pharmacist Consultant		1,328	10-6	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		318	12-6	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,492		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	30	329	10-8	52
53	TOTAL (lines 50 - 52)	30	$ 329		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BARRIS, JOAN	ADMINISTRATOR		$ 1,916
FRITZ, PATRICIA A.	ADMINISTRATOR		53,861
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,777

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 365,090
TOTAL (agree to Schedule V, line 17, col. 3)	$ 365,090
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ENTERPRISE	COMPUTER SYSTEMS	$ 280
ONEIL ENGINEERED SYSTEMS		350
CANASTRA, JAY	WEBSITE SUPPORT	1,680
VAN WECHEL, REBECCA	WEBSITE SUPPORT	1,680
WAGNER, CARI	HUMAN RESOURCES	5,596
SEE SUPPORT PG 25	ACCOUNTING	46,949
SEE SUPPORT PG 25	LEGAL	34,225
ENLOE DRUGS	PHARMACY CONSULTANT	1,328
KOPIN INTERIORS	KITCHEN DESIGN	2,094
POVLOTSKI, YURI	COMPUTER SYSTEM	210
CONTRACT NURSE AIDES	RECLASSED TO 10	329
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 94,721

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,241
Unemployment Compensation Insurance	65,300
FICA Taxes	340,649
Employee Health Insurance	81,287
Employee Meals	9,700
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE LIFE INSURANCE	2,379
LAB TESTS	39
EMPLOYEE AWARDS AND APPRECIATION	
LUNCHES, DONUT DAYS ETC.	14,600
TOTAL (agree to Schedule V, line 22, col.8)	$ 635,195

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,440
Advertising: Employee Recruitment	7,121
Health Care Worker Background Check	1,161
(Indicate # of checks performed)	
SEE SUPPORT SUPPORT PG 26	450
SEE SUPPORT SUPPORT PG 26	3,220
MARKETING SUPPLIES/INCENTIVES	10,073
ADVERTISING & BROCHURES	33,197
PROMOTIONS/EVENT	7,419
Less: Public Relations Expense	(17,492)
Non-allowable advertising	(29,923)
Yellow page advertising	(3,273)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,393

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,453
In-State Travel	3,516
Seminar Expense	4,960
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,929

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12	RELATED PARTY LINCOLNSHIRE PROPERTIES												
13	PAINTING AND REPAIR	2003	30,206				5,034	10,069	10,069	5,034			
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 30,206		$	$	$ 5,034	$ 10,069	$ 10,069	$ 5,034	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 72,468
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 9,700 Has any meal income been offset against related costs? NO Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

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	V- COLUMN 5 RECLASSIFICATIONS	Amount	Sch. V Line Reference
1			
2	EMPLOYEE MEALS	(9,700)	2
3	EMPLOYEE MEALS	9,700	22
4			
5	WEB SITE SUPPORT	(3,360)	19
6	WEB SITE SUPPORT	3,360	20
7			
8	PHARMACY CONSULTANT	(1,328)	19
9	PHARMACY CONSULTANT	1,328	10
10			
11	SOCIAL SERVICE CONSULTANT	(318)	10
12	SOCIAL SERVICE CONSULTANT	318	12
13			
14	INSERVICE TRAINER	(28,521)	10A
15	INSERVICE TRAINER	28,521	10
16			
17	CONTRACT NURSE AIDES	(329)	19
18	CONTRACT NURSE AIDES	329	10
19			
20	AANAC SEMINAR	(210)	20
21	AANAC SEMINAR	210	24
22			
23	AUTO LEASE PAYMENT	(2,031)	25
24	AUTO LEASE PAYMENT	2,031	35
25			
26	SW CONTINUING ED SPONSOR FEE	(350)	24
27	SW CONTINUING ED SPONSOR FEE	350	20
28			
29	SEMINAR AANAC	(985)	23
30	SEMINAR AANAC	985	24
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			
51	**Total**	0	

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XIX-C. Professional Services

Vendor/Payee	Type	Amount
ACCOUNTING:		
LERMAN BOUDART & ASSOC	ACCOUNTING	4,381
KRUPNICK,BOKOR,KAGDA & BROOKS	ACCOUNTING	7,210
FROST RUTTENBERG & ROTHBLATT	ACCOUNTING	(9,025)
DAVID HAFT	ACCOUNTING	20,829
RICHARD PEEBLO & ASSOC	ACCOUNTING	3,360
BARBER, MARY	ACCOUNTING	6,809
WILSON, ELIZABETH	ACCOUNTING	4,791
CORONADO, SUSAN K.	ACCOUNTING	6,650
ONG, ANTONIO A.	ACCOUNTING	1,944
TOTAL ACCOUNTING		46,949
LEGAL:		
ADELMAN GETTLEMEN MERENS ET AL	LEGAL	5,659
ASHMAN LAW OFFICE	LEGAL	2,569
LAW OFFICES OF SEGAL & SEGAL	LEGAL	6,202
LAW OFFICES OF JEFFERY ALBERT	LEGAL	1,137
SHARON DETLO BAUMAN ET AL	LEGAL	1,159
ASH ANOS FRIEDMAN & LOGAN	LEGAL	17,499
TOTAL LEGAL		34,225
		81,174

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XIX-F. DUES, FEES, SUBSCRITPTIONS AND PROMOTIONS

Vendor/Payee	Type	Amount
DUES AND SUBSCRIPTIONS:		
PARTNERS FOR WORLD CLASS BUSINESS		35
LAKE CTY WORK FORCE BOARD		15
MERION PUBLICATIONS		262
NATIONAL SUBSCRIPTION BUREA	LTC MAGAZINE	138
TOTAL DUES AND SUBSCRIPTIONS		450
LICENSES AND FEES:		
ILL DEPT OF PUBLIC HEALTH		35
SW CONTINUING ED SPONSOR		350
SECRETARY OF STATE	LICENSE PLATES	78
LAKE COUNTY HEALTH DEPARTMENT	BUSINESS LICENSE	204
BUNAK UK OPT	IMMIGRATION FEES	2,279
VILLAGE OF LINCOLNSHIRE	BUSINESS LICENSE	160
ILL COUNCIL LTC		69
HUCKLEBERRY NOTARY BINDING	NOTARY BOND	130
MISC CR		(85)
TOTAL LICENSE & FEES		3,220

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V -24 & XIX - G TRAVEL AND SEMINAR

Seminar	Attendee	Job Title	Location	Seminar	Travel	Total
AANAC - MDS TRAINING	PAT FRITZ	ADMINISTRATOR	LAS VEGAS	985	1148.56	2,134
	ELIZABETH WILSON	BILLING/ACCOUNTING				
	TERESA LIBRANDO	MDS COORDINATOR				
	ARNOLD GOLDBERG	PRESIDENT				
AAOD	ANTONIO ONG	BILLING/ACCOUNTING	FLORIDA	490	1304.86	1,795
	ZENY ENGRASSIA	CFO				
	SUBTOTAL OUT OF STATE			1475	2453.42	3,928
LUTHERAN GENERAL LOC ASESSMENTS	VIRGINIA ZAHN	SOCIAL SERVICE			12.4	12
SS IN LTC	VIRGINIA ZAHN	SOCIAL SERVICE		180	19.2	199
AAOD - IN HOUSE TRAINING - BILLING/ACCOUNTING	EISABETH WILSON	BILLING/ACCOUNTING		1054.82		1,055
						0
CROSS COUNTRY SEMINARS - MEDICARE BILLING IN LTC	ELISABETH WILSON	BILLING/ACCOUNTING		222.6		223
	ZENY ENGRASSIA	CFO				0
						0
NHA REVIEW	PAT FRITZ	ADMINISTATOR		385	59.47	444
NHA EXAM	PAT FRITZ	ADMINISTATOR		150.22		150
						0
LEWELLEN TECH - HVAC/BAS DIGITAL CONTROLS	STAN TKACY	MAINTENANCE SUPERV		486.5		487
						0
PRODUCTIVITY POINT INT'L - ADV WORD PROCESSING	MARTHA GILLESPIE	PAYROLL		147	350	497
						0
ADMINISTAR FEDERAL- MEDICARE INTERFACE UTILIZATION	ZENY ENGRASSIA	CFO		241.5		242
	BETH WILSON	BILLING/ACCOUNTING				0
						0
COLLEGE OF LAKE CTY - SANITATION	ALMA HUERTA	DIETARY			44.8	45
						0
DOCTORS ASSISTANCE CORP				275.8		276
						0
HARPER COLLEGE - SPEECH/COMMUNICATION	NGOSA LUMBWE	CN A		132		132
						0
FROST, RUTTENBERG, ROTHBLATT - MDS/RA	VIRGINIA ZAHN	SOCIAL SERVICE		210		210
	PAT FRITZ	ADMINISTATOR				
VARIOUS LOCAL TRAVEL FACILITY BUSINESS					3029.7	3,030
	SUBTOTAL IN STATE			3485.44	3515.57	7,001
	TOTAL			4960.44	5968.99	10,929

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V -25 OTHER ADMINISTRATION STAFF TRANSPORTATION

Type	Amount
AUTO INSURANCE	569
AUTO LICENSE	78
AUTO REAIR	2,471
A. GOLDBERG MISC FACILITY	1,822
Engracia, Zenaida	324
Gllespie, Martha	134
Wilson, Elisabeth	157
MISC	761
TOTAL	6,316

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V -19 AND VI-A -19 LEGAL FEES

Type	HR EMPLOYEE MATTERS	NOISE POLUTION SUIT	COLLECTIONS	FINANCING WC	Amount
Ash, Anos, Freedman & Logan	3,435	14,064			17,499
Adelman Gettleman Merens Berish				5,659	5,659
Ashman Law Offices			2,569		2,569
Sharon Dettlo & Baumann et al	1,159				1,159
Law Offices of Jeffrey Albert			1,137		1,137
Law Offices of Segal & Segal	798		5,404		6,202
NONALLOWABLE			(9,110)		(9,110)
TOTAL	5,392	14,064	-	5,659	25,115